

Child Member Health Record

Infant to 3 years old

ABOUT THE CHILD

NAME:		
ADDRESS:		
CITY:	STATE/ZIP CODE:	
HOME PHONE:		
DATE OF BIRTH:	AGE:	GENDER:
HEIGHT:	WEIGHT:	
SIBLINGS NAMES AND AGES:		

CHIROPRACTIC EXPERIENCE

WHO REFERRED YOU TO OUR OFFICE?
HAS YOUR CHILD EVER BEEN CHECKED FOR VERTEBRAL SUBLUXATION? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> DON'T KNOW
HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, WHAT WAS THE REASON FOR THOSE VISITS?
CHIROPRACTOR'S NAME:
APPROXIMATE DATE OF LAST VISIT:

GENERAL HISTORY

DOES YOUR CHILD EAT WELL <input type="checkbox"/> YES <input type="checkbox"/> NO ARE YOU AWARE OF THE IMPACT NUTRITION CAN HAVE ON YOUR CHILD'S BEHAVIOR? <input type="checkbox"/> YES <input type="checkbox"/> NO WOULD YOU LIKE MORE INFORMATION ABOUT NUTRITION FOR YOUR CHILD? <input type="checkbox"/> YES <input type="checkbox"/> NO
DOES YOUR CHILD HAVE DAILY BOWEL MOVEMENTS <input type="checkbox"/> YES <input type="checkbox"/> NO
DOES YOUR CHILD SLEEP WELL <input type="checkbox"/> YES <input type="checkbox"/> NO DOES YOUR CHILD SLEEP ON HIS/HER <input type="checkbox"/> SIDE <input type="checkbox"/> STOMACH <input type="checkbox"/> BACK PLEASE DESCRIBE HIS/HER SLEEPING HABITS:
HAVE YOU CHOSEN TO VACCINATE YOUR CHILD? <input type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, CHECK ALL THAT YOUR CHILD HAS RECEIVED: <input type="checkbox"/> DPT <input type="checkbox"/> MMR <input type="checkbox"/> CHICKEN POX <input type="checkbox"/> HEPATITIS <input type="checkbox"/> OTHER
DESCRIBE ANY AND ALL REACTIONS TO VACCINE (S):
LIST PRESCRIPTION MEDICATION/SUPPLEMENTS TAKEN:
LIST ANY ALLERGIES YOUR CHILD HAS :

REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT: <input type="checkbox"/> CONDITION <input type="checkbox"/> WELLNESS IF CONDITION, PLEASE DESCRIBE: IS THIS PROBLEM: <input type="checkbox"/> OCCASIONAL <input type="checkbox"/> FREQUENT <input type="checkbox"/> CONSTANT WHAT MAKES THIS PROBLEM BETTER? WHAT MAKES THIS PROBLEM WORSE?
IS THE PURPOSE OF THIS APPOINTMENT RELATED TO: <input type="checkbox"/> SPORTS <input type="checkbox"/> AUTO <input type="checkbox"/> FALL <input type="checkbox"/> HOME INJURY <input type="checkbox"/> OTHER
HOW DID THIS CONDITION START? <input type="checkbox"/> SUDDENLY <input type="checkbox"/> GRADUALLY <input type="checkbox"/> POST INJURY WHEN?
HAS THIS CONDITION: <input type="checkbox"/> GOTTEN WORSE <input type="checkbox"/> STAYED CONSTANT <input type="checkbox"/> COME AND GONE
DOES THIS CONDITION INTERFERE WITH: <input type="checkbox"/> SLEEP <input type="checkbox"/> DAILY ROUTINE <input type="checkbox"/> EATING <input type="checkbox"/> OTHER ACTIVITIES PLEASE EXPLAIN:
HAS THIS CONDITION OCCURRED BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO
HAVE YOU SEEN OTHER DOCTORS/CHIROPRACTORS FOR THIS CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO
DOCTOR'S NAME AND SPECIALTY:
TYPE OF TREATMENT/TESTING:
RESULTS:

ABOUT THE PARENT

PARENT/LEGAL GUARDIAN NAME:	
ADDRESS: <input type="checkbox"/> SAME AS ABOVE	
CITY:	STATE/ZIP CODE:
HOME PHONE:	CELL PHONE:
EMAIL ADDRESS:	
EMPLOYER NAME:	
WORK PHONE:	POSITION TITLE:

COMPLETE THIS PAGE FOR CHILDREN INFANT TO 3 YEARS OF AGE

BIRTH HISTORY

GROWTH & DEVELOPMENT

DID YOU EXPERIENCE ANY ILLNESS(S) WHILE PREGNANT? YES NO
 DID YOU SUFFER ANY TRAUMAS, FALLS, OR ACCIDENTS? YES NO
 PLEASE EXPLAIN:

DURING PREGNANCY DID YOU USE: MEDICATIONS
 TOBACCO/ALCOHO SUPPLEMENTS

IF YES, PLEASE LIST:

ULTRASOUND DURING PREGNANCY? YES NO NUMBER: _____
 MEDICAL REASON FOR ULTRASOUND?

LOCATION OF BIRTH: HOME BIRTHING CENTER HOSPITAL

WHAT WAS THE BABY'S GESTATIONAL AGE AT BIRTH? _____ WEEKS

DESCRIBE YOUR LABOR/DELIVERY, MARK ALL THAT APPLY:
 DRUG FREE SPONTANEOUS
 LABOR WAS CHEMICALLY INDUCED LABOR WAS DOCTOR ASSISTED
 C-SECTION DELIVERY FORCEPS/VACUUM EXTRACTION
 DOCTOR PULLED OR TWISTED BABY PREMATURE DELIVERY

PLEASE EXPLAIN:

HOW LONG WAS THE LABOR FROM THE FIRST REGULAR CONTRACTIONS TO THE BIRTH?

HOW LONG WAS THE 2ND STAGE (THE PUSHING PHASE) OF LABOR?

DESCRIBE ANY COMPLICATIONS EXPERIENCED DURING DELIVERY:

BIRTH WEIGHT:

BIRTH LENGTH:

APGAR SCORES: AT 1 MIN _____/10 AT 5 MIN _____/10

WAS BABY ALERT & RESPONSIVE WITHIN 12 HRS OF DELIVERY YES NO

DID YOU BREASTFEED THE BABY? YES NO

IF YES, HOW LONG?

DID YOU HAVE ANY DIFFICULTY WITH LATCHING OR LACATION? YES NO

DID YOU FORMULA FEED THE BABY? YES NO

IF YES, HOW LONG?

DID YOUR CHILD SHOW ANY OF THESE SIGNS OF BIRTH TRAUMA?

BRUISING STUCK IN THE BIRTH CANAL
 RESPIRATORY DISTRESS CORD AROUND NECK
 FAST OR EXCESSIVELY LONG BIRTH LACK OF USE OF ONE ARM
 ODD SHAPED HEAD HEAD ROTATED TO ONE SIDE

AT WHAT AGE DID THE CHILD:

HOLD UP HEAD _____ TEETHE _____

SIT ALONE _____ WALK _____

CRAWL _____ VOCALIZE _____

AT WHAT AGE DID YOU INTRODUCE:

SOLIDS:

COW'S MILK:

HOW MANY TIMES/WEEK DOES YOUR CHILD EAT FAST FOOD? _____

CANDY/COOKIES? _____ SODAS? _____

ARE YOU AWARE OF ANY FOOD OR JUICE ALLERGIES OR INTOLERANCE?

YES NO

HAS YOUR CHILD EVER TAKEN ANTIBIOTICS?

HOW MANY TIMES?:

HAS YOUR CHILD EVER BEEN HOSPITALIZED? YES NO

PLEASE EXPLAIN:

THE NATIONAL SAFETY COUNCIL REPORTS APPROXIMATELY 50% OF CHILDREN FALL HEAD FIRST FROM A HIGH PLACE DURING THEIR FIRST YEAR OF LIFE (I.E.: BED, CHANGING TABLE, STAIRS, ETC.).

WAS THIS THE CASE FOR YOUR CHILD? YES NO

PLEASE EXPLAIN:

HAS YOUR CHILD EVER BEEN IN A CAR ACCIDENT? YES NO

PLEASE EXPLAIN:

HAS YOUR CHILD EVER HAD SURGERY? YES NO

PLEASE EXPLAIN:

DOES YOUR CHILD HAVE DIFFICULTY INTERACTING WITH OTHERS?

YES NO

PLEASE EXPLAIN:

HAVE YOU OR ANYONE ELSE NOTICED THAT YOUR CHILD IS NERVOUS, TWITCHES, SHAKES OR EXHIBITS ROCKING BEHAVIOR?

YES NO

AT WHAT AGE DID YOUR CHILD START DAYCARE? _____

AVERAGE NUMBER OF HRS OF TV PER WEEK ? _____

ARE THERE ANY SMOKERS LIVING IN THE HOME? YES NO

ARE THERE ANY INDOOR PETS IN YOUR HOME? YES NO

DO YOU USE GREEN PRODUCTS IN YOUR HOME? YES NO

COMPLETE THIS PAGE FOR CHILDREN INFANT TO 3 YEARS OF AGE

CHIROPRACTIC KNOWLEDGE

ARE YOU AWARE THAT NOT ALL CHIROPRACTIC CARE IS THE SAME AND NOT EVERY CHIROPRACTIC APPROACH IS SPECIFIC?

YES NO

ARE YOU AWARE THAT CHIROPRACTORS WORK WITH THE NERVOUS SYSTEM?

YES NO

ARE YOU AWARE THAT THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL BODY SYSTEMS AND FUNCTIONS?

YES NO

ARE YOU AWARE THAT SYMPTOMS OFTEN TIMES ARE THE LAST TO SHOW UP?

YES NO

DID YOU KNOW THAT YOU CAN HAVE LOSS OF FUNCTION WITHOUT EXPERIENCING PAIN?

YES NO

DID YOU KNOW THAT CHIROPRACTIC CARE IS SAFE DURING PREGNANCY AND CAN HELP TO KEEP THE BABY IN OPTIMAL POSITION FOR LABOR AND DELIVERY?

YES NO

DID YOU KNOW THAT CHIROPRACTIC CARE CAN HELP CHILDREN FUNCTION OPTIMALLY TOO?

YES NO

SYSTEMS REVIEW

THE EFFECTS OF SUBLUXATION CAN BE BROAD AND FAR REACHING. THEY CAN SHOW UP AS OTHER HEALTH CONCERNS. PLEASE MARK ALL CONDITIONS/SYMPTOMS YOUR CHILD HAS EXPERIENCED:

- | | |
|--|---|
| <input type="checkbox"/> ACID REFLUX | <input type="checkbox"/> DIFFICULT WEIGHT GAIN |
| <input type="checkbox"/> BED WETTING | <input type="checkbox"/> LEARNING DISORDERS |
| <input type="checkbox"/> CONSTIPATION | <input type="checkbox"/> DIARRHEA |
| <input type="checkbox"/> EAR INFECTIONS | <input type="checkbox"/> FREQUENT COLDS/COUGHS/FLUS |
| <input type="checkbox"/> DIARRHEA | <input type="checkbox"/> HYPERACTIVITY |
| <input type="checkbox"/> COLIC | <input type="checkbox"/> HEDACHES |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> FEVERS |
| <input type="checkbox"/> POOR COORDINATION | <input type="checkbox"/> SORE THROATS |
| <input type="checkbox"/> BRONCHITIS | <input type="checkbox"/> ALLERGIES |
| <input type="checkbox"/> SLEEPING DIFFICULTIES | <input type="checkbox"/> URINARY PROBLEMS |
| <input type="checkbox"/> NECK PAIN | <input type="checkbox"/> UPPER BACK PAIN |
| <input type="checkbox"/> LOW BACK PAIN | <input type="checkbox"/> SHORTNESS OF BREATH |

PLEASE LIST ANY OTHER SYMPTOMS YOUR CHILD HAS EXPERIENCED:

FAMILY HISTORY

PLEASE MARK ANY CONDITIONS YOUR CHILD'S FAMILY MEMBERS HAVE BEEN DIAGNOSED WITH:

M = MOTHER F=FATHER S=SIBLINGS G = GRANDPARENTS

CANCER: TYPE _____ DEPRESSION M F S G DIABETES M F S G

HEART DISEASE M F S G LIVER DISEASE M F S G HIGH CHOLESTEROL M F S G

HIGH BLOOD PRESSURE M F S G LUNG PROBLEMS M F S G SEIZURES M F S G

NECK PROBLEMS M F S G BACK PROBLEMS M F S G SCOLIOSIS M F S G

OSTEOARTHRITIS M F S G RHEUMATOID ARTHRITIS M F S G

AUTOIMMUNE DISEASES M F S G

OTHER: _____

YOUR HEALTH GOALS

WHAT ARE YOUR TOP 3 HEALTH GOALS FOR YOUR CHILD?

1. _____
2. _____
3. _____

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

To receive text appointment reminders, initial here_____

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- *Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.*
- *Obtain payment from third party payers.*
- *Conduct normal healthcare operations such as quality assessments and physician's certifications.*

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

PATIENT NAME (PLEASE PRINT):	RELATIONSHIP TO PATIENT:
SIGNATURE:	DATE:

Authorizing Consent for Examination of a Minor (under 16 years old)

In order for the health professional as indicated below to make a determination on the suitability of my child's/ guardian's case for care, I acknowledge and understand that a thorough evaluation must be completed. I do hereby request and consent to the performance of such an evaluation by the person(s) named below, or any party authorized to do so by that person.

I have had the opportunity to discuss with the Doctor of Chiropractic indicated below, or with any party authorized to do so by that Chiropractor, about the nature and purpose of the examination process. I understand that there may be remotely associated risks with examinations, as there are with any and all healthcare treatments. In healthcare, the matter of whether any treatment is appropriate or not is determined by looking at the level of risk and comparing this with the level of expected benefit. I understand that I may ask the doctor to stop the examination at any time. I also understand that by signing this form, the chiropractor continues to be obligated for best practices delivered in the child's interests. Symptoms may change over the course of chiropractic care. Following the recommended schedule will ensure the best results.

Name: _____ Date: _____

Witness: _____ Date: _____

Doctor's Signature: _____ Date: _____